This form can be filled out while viewing in Adobe Acrobat Reader. Then print it and fax or mail to HID

PHARMACY OVERRIDE

REQUEST FORM

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
HEALTH INFORMATION DESIGNS

P.O. Box 3210
Auburn, AL 36832-3210

PATIENT INFORMATION

Patient name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____

Nursing home resident ❒ Yes

PRESCRIBER INFORMATION

Prescribing practitioner _____ License # _____

Phone # with area code

Fax # with area code

Address (Optional)
Street or PO Box /City/State/Zip

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Prescribing practitioner signature Date

DISPENSING PHARMACY INFORMATION

Dispensing pharmacy _____ Provider # _____

NDC # _____ J Code _____ Qty. requested per month _____

Phone # with area code _____ Fax # with area code _____

CLINICAL INFORMATION

❒ **Early Refill** ❒ **Maximum Unit/Maximum Cost** ❒ **Therapeutic Duplication** ❒ **Brand Limit Switch Over**

Requested drug name _____ Strength _____ Date of request _____

For Early Refill

❒ Medication lost
❒ Medication destroyed
❒ Physician changed the dosage
❒ Medication stolen
❒ Patient going out of town for period greater than the day's supply remaining of the previous refill.

Documentation _____

❒ Supporting Documentation Attached

For Maximum Unit or Maximum Cost

Diagnosis _____

Medical Justification _____

For Therapeutic Duplication or ◆Brand Limit Switch Over **Diagnosis** _____

Reason for Request ❒ **Strength/Dosage change*** ❒ **Switch over** ❒ **Titration and Concomitant Therapy****

❒ Drug name _____ NDC _____ Qty. _____ Stop date _____ if applicable

❒ Drug name _____ NDC _____ Qty. _____ Stop date _____ if applicable

Reason for change _____

* Stop date is required for strength/dosage change or switch over. ❒ Medical justification attached

** Attach medical justification if both drugs are to be continued (titration/concomitant therapy).

◆ For specific documentation requirement, see Override instructions on the Medicaid web site.

FOR HID USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments _____

_____ _____
Reviewer's Signature Response Date/Hour